Clarifications on State MMA Data Feed

[as of 6/30/05]

Note: Please see also the updated MMA State File Specifications and Data Dictionary issued June 30, 2005. This replaces the 4/28/05 Q&As. Please note, the question numbers are different on this version.

#	New?	Category	Clarification Requested	Clarification Provided
1		%FPL	Many states indicate they do not have income level in their centralized eligibility system, and cannot readily obtain it. Can they use dual status code and QMB indicator as a proxy, and build an algorithm to sort out the LTC folks by income?	If states do not have income level for beneficiaries, they should populate the %FPL IND with "9" (unknown). CMS will populate with default values based on dual status code.
2		%FPL	If the file value of '9' (unknown) is submitted in the FPL % IND field, what implications will this have for the recipient, the State, and the PDP? For example, if FPL % IND = '9', will the recipient receive information from CMS and/or the PDP indicating that their cost share is equal to the higher co-pay amount ($2/$5)?	If a state populates %FPL IND with "9" (unknown), CMS will populate with default values based on dual status code. CMS will notify both beneficiaries and plans of the appropriate level of copayments, which is determined by income level. Beneficiaries will not be automatically assigned the $2/5 copay level.
3		%FPL	The values for %FPL IND do not accurately reflect the income cut-offs for different co-pay levels in the final regulation.	The 12/6/04 Data Dictionary incorrectly listed the valid values as: 1=below 100% FPL, 2=100% or above FPL. **The correct values are: 1 = at or below 100% FPL, 2=above 100% FPL.** This has been corrected in the updated data dictionary.
4		%FPL	The description for this field states that 'FPL is determined by the state'. Will CMS accept whatever methodology we use to calculate the income amount used to establish financial eligibility and thus to establish whether the person is below or above 100% FPL, correct? Similarly, will CMS accept family size used to determine income? This means that persons with the same gross income, but living in different states, may be in different FPL groups in this file and thus for the Part D low income subsidy.	Yes, assuming states can provide us with data on income level, CMS accepts whatever methodology a given state uses.
5		%FPL	Although we understand the importance of designating those beneficiaries who are below 100% FPL for subsidy purposes, we may not have this information available for the test file. If we routinely 9-fill this element will the file be accepted? What are the consequences of not correctly populating?	As noted above, CMS is aware this data element is problematic for many states. States may submit test files with a "9" (unknown) value. If these data are not available at the time production files are submitted, states should continue to populate with "9" (unknown), and CMS will populate with default values based on dual status code.
6		%FPL	What is your need or intended use for the %FPL element?	The percent of Federal poverty level is needed to determine the level to which copayments will be subsidized for full-benefit dual eligibles. Those with income at or below 100% FPL will have copayments of $1-3. Those with incomes above 100% FPL will have copayments of $2-5.
7		%FPL	For medically needy (spenddown) dual eligibles, does the FPL% reflect income before spenddown or the level after spenddown is met?	It should be income before spenddown.

8	Changes to report	What specific situations constitute "changes in the circumstances for individuals that were effective in prior months" that would require a state to submit a new enrollment record for full-benefit dual eligibles and QMB/SLMB/QI? Would they include a change in any of the following fields: ELIGIBILITY STATUS; DUAL STATUS CODE; FPL % IND; DRUG COVERAGE IND; INSTITUTIONAL STATUS IND?	For enrollment records, the following changes should be reported: ELIGIBILITY STATUS, HIC, HIC-RRB IND, SSN, DOB, and DUAL STATUS CODE. The data dictionary has been updated to provide these instructions. Please see separate questions on when changes to %FPL IND and INSTITUTIONAL STATUS CODE should be reported.
9	Changes to report	Please clarify what changes in %FPL IND should trigger states reporting a change in value for this indicator. Should a value change be reported if an individual's income increases or falls below 100% FPL based on current income? If so, will it result in immediate or future increases or reductions in the beneficiary's cost sharing (co-payments)? The newly issued regulations at 42 CFR 423.773(c)(2) indicate that dual eligible individuals are determined subsidy eligible for a period of up to one year. Does this mean that the beneficiary's cost sharing will not change for this up to one year period regardless of what gets reported on the file subsequent to the initial reporting month (which establishes the person's eligibility status)?	States should submit changes in %FPL IND when a beneficiary's income goes from above 100% to at or below 100% FPL, or vice versa; they do not need to send records for retroactive changes in these data. Generally, CMS' policy is that within a deemed (calendar) year, changes to income or institutional status will only result in a copayment change if it would lower the beneficiary's copayment level, and then only prospectively. If a beneficiary's income drops from above to at or below 100% FPL, then CMS will reduce their copayment level from $2/5 to $1/3 prospectively (starting the month after the state data was submitted). This is true even if the state reports such a change on a retroactive record. If the income increases from at or below, to above 100% of FPL, CMS will not increase the copayment obligation within the current deemed year. However, assuming the income stays at the higher level, the beneficiary will have the higher copayment obligation the next deemed (calendar) year.
10	Changes to report	Please clarify what changes to the INSTITUTIONAL STATUS IND should be reported by states, both prospectively and retrospectively.	States should report a Y (yes) in to INSTITUTIONAL STATUS IND when beneficiaries are admitted to an institution for the full calendar month, or with the expectation that they will be admitted for a full calendar month. Similarly, states should submit an N (no) if the person is not, or not expected to be, in an institution for a calendar month. In both cases, retroactive changes do not need to be submitted. CMS' policy is similar to that for changes in %FPL: we will reduce a full-benefit dual eligible's copayment to $0 prospectively once we receive data the person is institutionalized. If they are later discharged within a deemed (calendar) year, we will leave them at the $0 copayment level the rest of the current deemed year, but will increase it for the following deemed (calendar) year (assuming the person is still not in an institution).
11	Changes to report	Please clarify what changes in the LIS determination fields should be reported by states.	For LIS records, the following changes should be reported: HIC, HIC-RRB IND, SSN, and DOB. ***Please see #57-59 for additional clarification.***
12	Drug Coverage	If the file value of '9' (unknown) is submitted in the DRUG COVERAGE IND field, what implications will this have for the recipient, the State, and the PDP? For example, if DRUG COVERAGE IND = '9', will the recipient receive information from CMS and/or the PDP indicating that their cost share is equal to the higher co-pay amount ($2/$5)?	The purpose of this field is to exclude full-benefit dual eligibles from the discount drug card program for the remainder of calendar year 2005; it is not linked to level of copayment for Part D plans. If the DRUG COVERAGE IND field is populated with "9", CMS will populate with default values based on dual status code during 2005. It will not be used starting January, 2006. A value of "9" will not have any impact on states, beneficiaries, or PDPs.

13	Drug Coverage	The DUAL STATUS CODE field indicates that the Medicaid drug coverage criterion only applies through December, 2005; is the same true of this field? If the DUAL STATUS CODE is 02, 04, or 08, should we submit this field with a 1 (Medicaid drug coverage) through December 2005, then 0 (no drug coverage by Medicaid) beginning January, 2006?	Yes, this is correct. The DRUG COVERAGE INDICATOR only applies through December, 2005. If the DUAL STATUS CODE is 02, 04, or 08, states should submit this field with a 1 (Medicaid drug coverage) through December, 2005. Starting January, 2006, please submit this field with a 9 (unknown).
14	Drug Coverage	Shouldn't states submit this with a 0 (no drug coverage by Medicaid) starting January, 2006, since states will not provide drug coverage to full-benefit dual eligibles?	CMS' preference is that states fill this field with a 9 (unknown) for all records (other than those for state determinations of low-income subsidy).
15	Drug Coverage	The 2/24/05 Q&As indicate that the DRUG COVERAGE INDICATOR is going to be used through December 2005 for exclusion from the Medicare discount drug card program. Does this mean that states will no longer be sending the drug card exclusion file currently submitted each month starting in June 2005 (when the new MMA State File goes into production)? If we are still going to submit the drug card exclusion file, and there are discrepancies between it and the MMA State File, please explain which would take precedence and if the State would be notified of the discrepancy.	States should continue to submit the drug card exclusion file until instructed to cease doing so, which will likely be sometime in 2006. No active comparisons will be done between it and the new MMA State File; the files will be processed separately.
16	Dual Status	What if a state populates the DUAL STATUS CODE field with "99" (unknown) or an invalid value, or leaves it blank?	~~CMS cannot accept a DUAL STATUS CODE populated with "99", an invalid value, or left blank.~~ Without a valid value CMS cannot assign correct level of low-income subsidy, auto-enroll, or calculate state phasedown contributions. C~~MS will send the record back to the state for correction~~ **CMS will highlight the need for states to correct an invalid DUAL STATUS CODE in future submissions. Specifically, in CMS' Response File to states, if the DUAL STATUS CODE field was left blank, the Error Return Code would be 01 (Value is not in Valid Value Set). If the DUAL STATUS CODE was 99 in the record, then the Error Return Code would be 40 (Warning - Value is 99 for Dual Eligible record).**
17	Dual Status	Please clarify whether the DUAL STATUS CODE values are the same as currently used in MSIS and the MSIS Dictionary.	Yes, the DUAL STATUS CODES are the same as currently used in MSIS.
18	Dual Status	"Status Code 05" represents "Eligible - Is entitled to Medicare - QDWI." Are QDWI's considered a "dual?" It appears the final rule does not consider them as a "dual." If not, why would a State be expected to include QDWI's on the enrollment file to CMS?	QDWI's are considered duals, in that they are eligible for Medicare and some level of Title XIX benefits, but they are not full duals. The questioner is correct in that QDWIs are not deemed eligible for LIS, not auto-enrolled, and there is no phasedown state contribution associated with them. CMS would still like states to report these individuals with the 05 DUAL STATUS CODE, in part to ensure that they are not inadvertently included in another DUAL STATUS CODE.
19	Eligibility Status	If a person is closed for Medicaid within a given month, but the specific closing date is after the monthly MMA File has been sent to CMS, do we report the closure with Eligibility Status of "N" (no) in the following month?	No, unless the person was ineligible for the whole of the previous month.

20	Institution	We are unclear on the expectation for this data element. Is it one day in an institution, or only if someone determined to be institutionalized (no longer in the community)? The state has only long term institutionalized indicator, and they expect significant lags in determination time for institution status.	The expectation is that if a person meets **or is expected to meet** the definition of institutionalized individual in section 1902(q)(1)(B) of the Social Security Act, in one of the institutions defined in 42 CFR 435.1009, then the indicator should be set at "Y" (yes). This applies if a person is institutionalized for the entire month; partial months do not qualify. The purpose of this data is to meet the requirement of imposing $0 copayment on full-benefit dual eligibles who are institutionalized. CMS is aware of the inherent lags in states receiving this data. ***Please see #24 for additional clarification.***
21	Institution	If the file value of '9' (unknown) is submitted in the INSTITUTIONAL STATUS IND field, what implications will this have for the recipient, the State, and the PDP? For example, if INSTITUTIONAL STATUS IND = '9', will the recipient receive info from CMS and/or the PDP indicating that their cost share is equal to the higher co-pay amount ($2/$5)?	If the INSTITUTIONAL STATUS IND is submitted with a 9 (unknown), a full-benefit dual eligible will be subject to $1/3 or $2/5, depending on their percent of FPL. CMS is aware of the lag in states receiving this data.
22	Institution	What about Intermediate Care Facilities for the Mentally Retarded -- are they included in the Intermediate Care Facility definition for this field?	If the ICF/MR meets the definition of medical institutions in section 1902(q)(1)(B) of the Social Security Act, and 42 CFR 435.1009, it qualifies as a medical institution for purpose of this data element. Please note that not all ICF/MRs qualify as a medical institution.
23	Institution	The data dictionary describes this element as a Part D enrollee who is in a long term care institution for even one day during an eligible month. As CMS knows, there are situations where we do not know if a patient is eligible as a dual eligible for services rendered in months prior to the eligibility determination AND because the only way we know whether many dual eligibles are an inpatient is when we pay the bill, which can occur many months after the month of eligibility. This is a major problem that will be undergoing constant reconciliation and will take substantial resources to install the monitoring system that can track retroactive eligibility and lagged payments for institutionalized dual eligibles.	While the data dictionary is silent on the duration of patient stay; the correct instruction is that this data element should be filled with a Y if a beneficiary is institutionalized for the full month; partial month stays should be coded with N. CMS is aware of the inherent delays in states receiving this data. ***Please see follow-up clarification below.***
24	Institution	Please clarify what is meant by "month" in the previous instruction to code a beneficiary as Y (yes) for INSTITUTIONAL STATUS INDICATOR only if they are institutionalized for a full month. One state has a monthly cutoff of the 15th, so institutionalized would always have to be reported retroactively in the following month. Another state interpreted this instruction to mean they had to wait for a month's bill to be submitted by the institution before they could send CMS a record (which would mean institutional status would always have to be submitted as a retroactive record).	CMS shares these concerns about additional delays in sending institutional status data. As a result, we are further clarifying our previous instructions with respect to length of stay that qualifies as an institutional stay. A person should be considered institutionalized if they are in an institution for the calendar month or are in an institution *with the expectation* that they will be in the institution for that calendar month. We believe this gives states the flexibility to use other sources of data besides a full month's bill. Examples include a long-term care eligibility coverage group, and an indication on an MMIS or eligibility system of institutional status. Please note that we do not have the flexibility to use a different definition of institution (as discussed in other Q&As).

25		Institution	Is the Institutional Status Indicator intended to identify clients who are eligible for institutional care, or clients actually receiving intuitional care?	It is intended to identify beneficiaries who are actually receiving institutional care.
26		Institution	Is the Institutional Status Indicator intended to identify clients who are receiving institutional care for partial months?	No, it is intended to identify clients who are institutionalized throughout the entire month.
27		Institution	Does institutional care include swing bed (beds considered nursing home beds in an acute care hospital)?	Yes, it does include swing beds.
28		Institution	Are the inpatient psychiatric hospital stays mentioned in the data dictionary limited to facilities enrolled as psychiatric hospitals, thereby excluding a psychiatric bed in a general acute care hospital?	Yes, it is limited to facilities enrolled as psychiatric hospitals; it does not include psychiatric beds in a general acute care hospital.
29		Institution	Do the inpatient psychiatric hospital stays mentioned in the data dictionary include or exclude residential psychiatric treatment centers?	Psychiatric residential treatment facilities for individuals under 21 qualify as institutions.
30	Pending	Institution	When a recipient is an inpatient in an acute care hospital for more than 30 consecutive days, Medicaid policy treats this a 'long term care' living arrangement with a patient liability to the hospital, etc. How are we to define it for purposes of the 'INSTITUTIONAL STATUS IND' field?	*Answer pending.*
31		Institution	Does institutional care include administrative wait beds? Administrative wait beds are acute care beds in an acute care hospital resided by a patient at a nursing home level of care who is waiting for the availability of a bed in a nursing home.	Yes, it does include stays in administrative wait beds.
32		Institution	Are bed hold days considered institutional stays? Bed hold days are days when a nursing home bed is held for a nursing home resident who is temporarily admitted to an acute care hospital.	Yes, bed hold days are considered institutional stays.
33		Institution	If a person is institutionalized, and is formally discharged for a temporary period (e.g. to be admitted to an acute care hospital), and then re-enters the institution, is the person considered institutionalized for the full month? If we identify this break, do we code INSTITUTIONAL STATUS INDICATOR as N (no) for that month? If we cannot identify this break, do we use code 9 (unknown) for the month?	In this scenario, the person is considered institutionalized for the full month, and INSTITUTIONAL STATUS INDICATOR should be coded Y (yes).
34		Institution	Will CMS be using the institutional indicator from state Medicaid agencies to determine copayment levels or will that data come from another source?	At this time, CMS intends to use only state data to determine copayment levels.
35		Institution	When a beneficiary dies in a month while in the institution from the first of the month, should the beneficiary be considered institutionalized for the full month?	Yes.
36		Institution	Are beneficiaries in Home and Community Based Waivers considered institutionalized?	No.
37		Institution	Are beneficiaries in Programs for All-Inclusive Care for the Elderly (PACE) considered institutionalized?	No.

38	Institution	One state expressed a concern that there is no information on its Medicaid Eligibility Data System that identifies an individual receiving inpatient psychiatric hospital services, i.e. for purposes of coding INSTITUTIONAL STATUS INDICATOR as Y.	In this instance, the state would need to identify the system that did have these data, and obtain them from that system to populate the field accurately.
39	LIS	Will CMS consider alternative reporting processes for states that may not be able to produce all of these data elements in the format requested? Some states are concerned about spending significant resources to program new systems for a few state LIS determinations.	No, States must submit data on LIS in this same file as the data on dual eligibles, as presented in the data dictionary. However, we note that CMS has no requirements about how states collect and store the data; just how the data need to be submitted to CMS.
40	LIS	Can states submit records on LIS determinations in a separate file from the dual eligible records?	No, States must submit data on LIS in this same file as the data on dual eligibles, as presented in the data dictionary.
41	LIS	Will each enrollment record on the file have a default '9-filled' values for the Part D low-income subsidy determination unless this determination originates from the state?	Yes.
42	LIS	If the state is determining the subsidy eligibility, is it correct that a complete enrollment file record will still be reported with several fields being blank (i.e. HIC, SMA identifier, etc.)?	Yes. The fields that will always be blank when a state submits a state determination for low-income subsidy are: ELIGIBILITY MONTH/YEAR, ELIGIBILITY STATUS, DUAL STATUS CODE, %FPL IND, DRUG COVERAGE IND, and INSTITUTIONAL STATUS IND. At the State's option, the SMA IDENTIFIER field may also be left blank.
43	LIS	For a State determination of LIS, which fields in the upper half (beneficiary identifiers) are mandatory?	The mandatory beneficiary identifier fields for a state low-income subsidy determination are: RECORD IDENTIFIER, HIC, HIC-RRB IND, SOCIAL SECURITY NUM, FIRST NAME, LAST NAME, MIDDLE NAME, SUFFIX NAME, SEX, DATE OF BIRTH.
44	LIS	Files are to be created no earlier than the 15th of each month and received at CMS between the 15th and the last day of each month. When will subsidy information be available to PDPs and MA plans? For example, will January file information be available for February 1 enrollments or for some other date? Excessive lag time between subsidy eligibility reporting and actual PDP enrollment are neither in the applicant nor the State's best interest.	Data on a beneficiary's low-income subsidy status is available to plans as soon as the data is validated and posted on the MBD. Depending on the validation routine, this should be within a day or two of CMS receiving the data. In this example, the January file will be available to PDPs in late January or early February (depending on when in January the file was submitted).
45	LIS	When should LIS subsidy application information be included on the record? Is it only when the state submits an application? Should the information remain on the record after the individual is approved or denied? Should the information be included as soon as the application is submitted and the individual is not yet determined eligible to indicate "in process" enrollment requests?	When a state receives a request for a state determination of low-income subsidy eligibility, it should only submit a record at the time an application is approved, disapproved, redetermined, appealed, or there is a subsidy-changing event. It should not submit information on applications that are in process, i.e. for which final determination has not been made.
46	LIS	Please clarify that when the State forwards LIS application information to SSA, that that is the end of their responsibility, and the LIS portion of the record will not be touched by them nor sent in to CMS. SSA will send the information to CMS because it is their determination.	Yes, if a state assists an individual in filling out the SSA LIS application, and forwards the application to SSA, that is the end of the state's responsibility. States do not communicate such an action to CMS via this data feed; rather, SSA will communicate to CMS the results of its determination.

47		LIS	If the state processes an LIS application and determines that the person is not eligible in February, then the person comes becomes a dual eligible effective in May, does the CHANGE TO PREVIOUS INDICATOR field need to be a Y or would it be a" 9" (unknown)? The reason that I am asking is that we are considering having our local eligibility determination group create the records for the LIS applications and forwarding it to our fiscal agent. This file will simply be attached to the dual eligibles records. If we have to change that indicator to Y, then we will not be able to use this approach.	In this situation, the state need not fill the CHANCE TO PREVIOUS DETERMINATION INDICATOR field with a Y; it would fill it with a "9" (unknown). When CMS receives a record from the state on a new dual eligible, CMS systems will make the deemed status prevail.
48		LIS	We do see major issues in the production of the second half of the file (LIS applications processed by the state). Although we were anticipating the need to report this information, the level of detail needed came as a surprise. Major modifications to both our eligibility and MMIS systems would be needed to report many of these elements, as we do not currently capture some items in any system right now (e.g., appeal information and denied applications). Which of the elements are optional? Can you provide an explanation for the necessity for each required element?	CMS is aware that designing and implementing a system to determine LIS eligibility has a substantial impact on states. The fields are required, depending on the type of action being communicated by the state (e.g., approval, denial, appeal). Separately, CMS will issue operational guidance on state determinations of LIS.
49	Pending	LIS	What LIS-specific fields are mandatory when a state submits an initial LIS approval?	*Answer pending.*
50	Pending	LIS	What LIS-specific fields are mandatory when a state submits an initial LIS disapproval?	*Answer pending.*
51	Pending	LIS	What LIS-specific fields are mandatory when a state redetermines a beneficiary eligible for LIS?	*Answer pending.*
52	Pending	LIS	What LIS-specific fields are mandatory when a state does NOT redetermine a beneficiary as eligible for LIS?	*Answer pending.*
53	Pending	LIS	What LIS-specific fields are mandatory when a state submits a record on an LIS appeal that was successful?	*Answer pending.*
54	Pending	LIS	What LIS-specific fields are mandatory when a state submits a records on an LIS appeal that was denied?	*Answer pending.*
55	Pending	LIS	For an LIS approval or redetermination, does the PART D % OF FPL field have to be filled, or is it sufficient for the PART D SUBSIDY LEVEL to be filled?	*Answer pending.*
56		LIS	What are the "limits" referenced in RESOURCE LEVEL (for which valid values are 1=over limit, and 2=under limit)?	This is the alternative resource limit of $6,000/individual or $9,000/couple. Specifically, "1=over limit" means resources are over $6,000/$9,000; "2=under limit" means at or below $6,000/$9,000. These data are needed because an LIS applicant with income at or below 135% FPL, and resources under this alternate limit, is eligible for the full LIS subsidy (100% premium, plus $2/5 copayment). An LIS applicant with income under 135% FPL but over this alternate resource limit will have partial LIS subsidy (100% premium, but 15% coinsurance).
57	Pending	LIS	When should a state fill out the CHANGE TO PREVIOUS DETERMINATION field?	*Answer pending.*

58	Pending	LIS	If CHANGE TO PREVIOUS DETERMINATION is filled with Y (yes), what other fields are mandatory?	*Answer pending.*
59	Pending	LIS	When should a state fill out the DETERMINATION CANCELLED field?	*Answer pending.*
60		LIS	What is a denied application? Is it any Medicaid denial for a person with Medicare parts A or B? Is it only those formal requests for subsidy? When can we expect policy guidance to support the production of the file to be released?	States should report denials only for formal requests for state determinations of low-income subsidy. A denied application is one that was denied for lack of Medicare A or B enrollment; residing outside the 50 states or D.C. ***or incarcerated*** ; failure to cooperate; resources too high; and income too high. We have updated the data dictionary with valid denial reason codes.
61		LIS	For purposes of the test file due March, 2005, may we space fill (with "9") these fields until CMS provides more guidance? States do not have enough information to fill these fields.	Yes, the LIS fields may be submitted with "9" in the March test files.
62		LIS	What is the procedure if a beneficiary requests and receives a state LIS determination, but is already a dual eligible? The state will already created an enrollment record with the "top half" of the file is filled out. Does the state just fill out the bottom half of that same record, or submit a separate record with the LIS determination?	In this situation, the state may cease processing the request for the LIS application, since the beneficiary will be deemed eligible for LIS based on their Medicaid status (full dual or QMB/SLMB/QI). However, if the state does process the application, and submits the results to CMS, the LIS determination should be submitted as a separate record. CMS uses the RECORD IDENTIFIER to route records to separate processing path, and could not accommodate both purposes on the same record.
63		LIS - SSA determine-nations	How will information on those determined eligible for LIS by SSA be sent to States? Will it be sent by SSA via the current Bendex file? Will it be a full file of all clients determined LIS eligible by SSA, or just updates? What triggers the inclusion of clients on the file?	SSA does not intend to include it on the Bendex file at this time. Instead, SSA will send it to CMS, who will forward it to States. CMS will send this data to States, and is currently working on how to do so.
64		LIS - SSA determine-nations	What data elements will be on the file CMS sends of those who apply for LIS at SSA? In order to properly screen SSA LIS applicants for Medicare Savings programs, we would need all the data collected by SSA. However, if fewer data elements are sent, we would not be able to adequately determine MSP eligibility. This is especially a concern if we are required to screen all SSA LIS applicants for MSP.	The data elements will be a subset of those on the SSA application, specifically: Subsidy Approved/Denied (Y/N); Subsidy Approval/Disapproval Date; LIS Effective Date (first day of month of application); Resource Over/Under Alternative Limit ($6,000/individual or $9,000/couple); Income Used for Determination (Individual/Couple); Income as % FPL; Denial Reason (no Medicare; not in USA (including incarcerated), failure to cooperate; resources too high; income too high); and Mailing Address
65		Partial month	The enrollment file appears to only include individuals who are eligible in the reporting month. Should individuals be included even if they are eligible for only part of the month? Should individuals be included only if eligible on the first day of the month?	Any individuals with Medicaid/Medicare dual eligibility for any part of the reporting month are to be included. Any accretions after the file is produced should be included as retroactive eligibles on the following month's file.
66		Phasedown	The State Contribution payment process for the Part D program has been described as "similar" to the Part B Buy-In program. What is the "same" as Part B and what is different from Part B? For example, Part B Buy-In changes involve accretions/deletions, yet it appears that CMS wants Part D to entail a full replacement.	The billing cycles and requirements applied to billing are the same. The file submittal is different in that the Buy-In program uses a base file with frequent updates and date spans, and the MMA file is an enrollment file that reports person months of enrollment. This file is also used for multiple purposes including phasedown, LIS, and auto-enrollment.

67		Response file	Regarding the two pieces of work that are still under development, what will be the general framework of those files? Of particular interest, because of their impacts on our fiscal estimating, will be the degree of accuracy required. Obviously, if a high degree of accuracy is required, the more lead time and resources will be necessary to accomplish the requisite system redesign.	The response file will include return records, edits, match flags, and information on individual's Medicare status (including Parts A, B, C (Medicare Advantage), and D (prescription drug)). Please see updated MMA Data Dictionary issued 3/10/05 for all element except new Part D data elements (for latter, see next question below).
68	***Modified***	Response file	Will Part D enrollment information be include on the response file back to States?	Yes. The data elements are: PDP or MA-PD Enrollment Start Date; PDP or MA-PD Enrollment End Date; PDP or MA-PD Plan Number; Level of LIS (copay level); Whether Person Affirmatively Declined; First Date of Part D Eligibility; and Whether Person Auto/Facilitated Enrolled or Voluntarily Enrolled. ~~As of 4/20/05, these are not yet in the state response file, but will be added in the near future.~~ **The data elements and file format specifications were included since the 5/17/05 version of the MMA Data Dictionary.**
69	New	Response file	In the response file, what does "Group Health Organization" in positions 1463-1672 refer to?	"Group Health Organizations" refer to coordinated care plans such as Medicare Advantage and cost plans. These fields reference specfically the larger organization that contracts with CMS. Please see item below for discussion of specific plans offered by the organizations.
70	New	Response file	In the response file, what do "MBD GHP" and MBD PBP" in positions 1673-1962 refer to?	"MBD" is the Medicare Beneficiary Database. "GHP" stands for Group Health Organization (see item above). "PBP" stands for Plan Benefit Package, a specific coordinated care plan offered by the larger "GHP" organization.
71	New	Response file	In the response file, what does "(10 Occurences)" mean in the different places it appears?	Each occurance is a span of enrollment in a given plan. For example, if a beneficiary is in Plan A from January-March, that is one occurance; in Plan B in April, that is the second occurance; and plan C from May-October, that is the third occurance.
72	New	Response file	In the "BENE COPAY LEVEL" field, it describes the valid values as "HIGH," "15%", "LOW," AND "0." What do these mean? Why are there diffent levels if BENE LIS TYPE is L (applied and determined eligible for LIS) or D (deemed automatically eligible for LIS)?	For those receiving the low-incomes subsidy, their cost-sharing on a per perscription basis will be one of four levels. For those who apply to SSA or States and are determined eligible, they will have a cost-sharing level of either HIGH ($2/5) or 15%. For those deemed LIS eligible, they will have a cost-sharing level of either HIGH ($2/5), LOW ($1/3), or 0 (zero, for full duals who are institutionalized).
73	New	Response file	What does the BENE CONTRACT NUM field refer to?	This is the contract number for the larger Part D organization (Medicare Advantage Organization or PDP Sponsor) that contracts with CMS. These larger organizations may offer a number of plans.
74	New	Response file	What does the BENE PTD PBP PLAN ID field refer to?	It refers to the specific plan in which the beneficiary is enrolled. The specific plan can be one of a number of plans operated by an Medicare Advantage Organization or PDP sponsor.
75	New	Response file	How do States find out more detailed information about the Medicare Advantage plans and PDPs in which beneficiaries are enrolled?	Health Plan Management System (HPMS) is a web-based system. It is accessed by all the Medicare Advantage manaed care plans when they enter/update their annual plans and packages and then it is accessed by many other entiteis to look up information about the plans. It will include PDP data as well. States have the option to request access to this system so that they can pursue the more detailed information on PBPs, for example. However, they must first contact Don Freeburger (CBC) to set up access. His phone is 410-786-4586, his email is donald.freeburger@cms.hhs.gov.

76	Retroactive	How many months back should accretion/deletion information be provided (i.e., will CMS require all retroactive changes back to the start of Part D or some moving timeframe)?	At this time, CMS is not limiting how far back retroactive records should be submitted on a rolling basis. For now, retroactive records should not be submitted for enrollment months prior to March, 2005.
77	Retroactive	What is the purpose of submitting retroactive records? Do they retroactively determine eligibility for Part D or the low-income subsidy?	Retroactive changes could affect the level of low-income subsidy. Retroactive counts of full benefit dual eligibles would affect the phasedown state contribution payment. We have not resolved how many months retroactive coverage we will act on.
78	Retroactive	If we previously reported someone as eligible, and for some reason, other than death, we have now determined them not eligible, how far back are we to report these "no longer eligible" changes? What is the impact if eligibility for subsidy was already established and drug benefits already paid?	For purposes of LIS deeming, CMS will not retroactively cancel their LIS deemed status. If their entire Medicaid/QMB/SLMB/QI span was cancelled (i.e. person should never have been deemed LIS in the first place), CMS will cancel their LIS deemed status prospectively, for the remainder of the deemed (calendar) year. If the person's Medicaid/QMB/SLMB/QI status simply ended within a deemed year, the person would continue to be LIS eligible for the remainder of the current deemed year, but would not be deemed for the following year. NOTE that for phasedown billing purposes, the state must submit any retroactive determination of eligibility or loss of eligibility to ensure accurate phasedown payments.
79	Retroactive	Do we send an Eligibility Status of "N," not eligible, for the current Eligibility Month if we had previously reported them eligible in the prior months, i.e. the client's eligibility closed? Or are "N" records only submitted for retroactive changes and current non-eligible clients are just not sent at all on the current month's file?	Do not send an "N" record for the current month in this situation. We only count records present, and only need the "N" designation to remove a prior month enrollment. We do not need an "N" to show loss of Medicaid eligibility.
80	Retroactive	When determining when to submit a retroactive change, should a state exclude someone ONLY if the person was deceased for the ENTIRE month (the data dictionary uses March as the example).	Yes, only those deceased for an entire month should be submitted as a retroactive change.
81	Retroactive	Will we need to include "retroactive records" for changes in any of the fields or changes to only certain fields (e.g. the three examples in the data file spec) in the enrollment record layout?	Please see questions #8-10.
82	Retroactive	If a beneficiary is already enrolled in a Medicare Part D plan, and becomes retroactively eligible for Medicaid or Medicare Savings Program (QMB/SLMB/QI), will the beneficiary be deemed retroactively eligible for low-income subsidy? How far back can a beneficiary be deemed eligible for LIS?	Yes, the beneficiary would be deemed retroactively eligible for LIS. At this time, CMS is not limiting how far back a person could be deemed eligible for LIS.
83	Retroactive	If a state submits a record for someone as dual eligible in a given month (e.g. March), and later finds out the person did NOT have MEDICARE, how does the state submit a retroactive correction? What DUAL STATUS CODE should be used? Should it be "00"?	Since this individual should not have been submitted at all, the record with the retroactive correction should be submitted as follows: ELIG MONTH/YEAR = the retroactive month affected; ELIG STATUS = N; DUAL STATUS CODE=9-filled (unknown); HIC/SSN/DOB/SEX/NAME = data included on original record.
84	SMA	What is the STATE MEDICAID AGENCY IDENTIFIER? Should the State use the Medicaid ID number that is unique for each recipient?	SMA IDENTIFIER is an optional field for State use to aid in States being able to track return records.

85	SPAP	It appears that the file should contain Medicare/Medicaid dual eligible individuals. Connecticut's Medicaid agency also administers a State Pharmacy Assistance Program (SPAP). Will there be a separate SPAP file? If so, are SPAP members to be excluded from this file? What about individuals who are both partial duals (i.e., QMB, SLMB, and QI-1) and SPAP members? What about individuals who may have been full duals for part of the month and SPAP members the balance of the month?	Those who are SPAP enrollees only, and are not dual eligibles, should not be included on the State MMA file. Beneficiaries should be included on this file if they are dual eligibles for any portion of the month, even if they convert to SPAP members for the remainder of the month.
86	SPAP	My understanding is that the State MMA file's purpose is not PDP enrollment, but rather to transmit dual eligible and low income subsidy determination data to CMS. Since your answer does not speak to a separate file for SPAP members for this purpose, please confirm that the State MMA file should include records for all full and partial Medicaid and Medicare dual eligibles, and in the subsidy determination section, records for any individuals determined subsidy-eligible by the state, and that all such records should be provided irrespective of SPAP enrollment status.	Yes, this is correct.
87	Who to include	Please confirm that the enrollment file contains only actively enrolled dual eligibles for the current month and accretions/deletions from any previous months (retroactive records).	Yes, this is correct.
88	Who to include	What defines active enrollment? Would a person need to be Medicaid eligible for an entire month? At least one day of the month? Or on the day that the State File extract is produced?	Any enrollment during the month which entitles the beneficiary to Medicaid payment for Medicaid services, including Medicare premiums for QMB and SLMB-only individuals. If the individual is listed on the Medicaid enrollment fields as in "suspense" until they meet spenddown, but that individual continues to receive limited Medicaid payment for Medicare premiums, they would be included on the file.
89	Who to include	One state has day-specific eligibility. Does day-specific eligibility have any implications for the definition of active enrollment?	No.
90	Who to include	Should the State file for each month include a full file of eligibility for the given month, or the full file of eligibility for all months?	The file should include all dual eligibles in the reporting month, and any retroactive records representing changes in the prior month.
91	Who to include	If a beneficiary is certified for medically needy spenddown, are they only reported in a given month's MMA File IF the spenddown is met before the cut-off date for generating that month's file? For example, if the beneficiary is certified on March 21st, but the MMA File is generated on March 15th, should the person be included? If not, would the person be reported in April's MMA File as retroactively eligible?	The State should only report a medically needy beneficiary in the current month's MMA File if the beneficiary met spenddown prior to the cut-off date for the MMA File for that month. In this example, the beneficiary would not be reported on the March MMA File; instead, the would be reported on the April MMA File with a retroactive record for March.
92	Who to include	One state continues to buy-in to Medicare for medically needy, even if the person does not meet their Medicaid spenddown in a given month. The first paragraph on p. 3 of the MMA Data Dictionary says those who have not met spenddown should not be reported. Is this accurate, or should we just report them under a different DUAL STATUS CODE? If so, what DUAL STATUS CODE should be used in this situation?	States should continue to submit an enrollment record in this situation, but with a different DUAL STATUS CODE. They should not code the person as a full-benefit dual eligible in this situation. Instead, the State should code the person as 01 (QMB-only) or 03 (SLMB-only), as appropriate.

93	Who to include	Should children with SCHIP and Medicare be included in this file?	No. SCHIP eligibles should not be included in in this file, as they do not meet the definition of dual eligibles for purposes of Part D.